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ABSTRACT

This guide presents information, direction, and resources to help teachers design a curriculum on suicide prevention tailored to their students' needs. Chapter I describes the problem of adolescent suicide at one high school and the program that developed as a result of that problem. Chapter II presents facts about suicide under the headings of incidence, sex and age, marital and occupational status, sociocultural factors, methods, and intent. In chapter III, 13 misconceptions about suicide are discussed. Chapter IV lists warning signs and causes of suicide as they relate to previous suicide attempts, suicide threats, depression, behavioral change, and stress. The information in chapter V is focused on how to help potential suicides. Suggestions are given for appropriate responses to a suicide threat. Six steps in intervention are outlined which are appropriate for dissemination at the seconday school level and which may be used by both students and teachers. Chapter VI contains an activity packet of resources for teachers which includes two suicide quizzes, a poem written by a boy who committed suicide, a suicidal anecdote, activity and work sheets, and a list of topics for discussion. Chapter VII consists of a bibiliography with 179 entries. Appendices contain other relevant forms and information. (NRB)

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Adolescent Suicide Prevention:
A Compendium of Resources

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Edited by:

Richard A. Abramson, M
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November, 1982

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c 1982 Richard A. Abramson and Michael Wing

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Suicide Prevention Curriculum Packet

Abstract: The Suicide Prevention Curriculum Packet has been designed by the MSAD #11 Suicide Prevention Committee, and updated by Michael Wing of Gardiner Area High School and Rich Abramson, Director of Special Services to serve educators, health professionals, and interested persons in their efforts to present an often difficult topic to their students. The information within is intended to lead the instructor to ideas for preparation and presentation, not to serve as an inflexible teaching outline. The emphasis and scope should be dependent upon the student needs as determined by the instructor's evaluation of student characteristics. The intent of the packet designers is to provide information, direction and resources.

Gardiner Area High School has a population that averages one thousand. The towns in the district are rural. Poverty is not unknown. Neither is wealth. Homes are often without both natural parents due to the usual divorces and deaths. The majority of the senior class goes to work or to marriage rather than higher education. We have our success stories and we have our tragedies. Everything sounds fairly average. However, our exception was an epidemic of teenage suicides.

Identification was simple, manifest in the unforgiving obituaries. Reaction was immediate in the forms of survivor groups, yearbook dedications, committees to investigate and implement, and a collection of relevent books in the school library. After only three years of effort, an effective program has grown. We are now informed, sensitive, experienced and even a bit confident. But, there always remains the nagging threat in the backs of our minds that a suicide will surprise us all, unattended by all the plans and prevention methods. Such is the nature of the act and the adolescent.

Other communities that we have contacted breath a sign of relief that they do not share this suicide problem or that they only have experienced one or two in several years. Caution. Because the manifestation of the act is not present or is not dominant does not mean that the potential does not exist. It exists if students are troubled and if these troubles are presently exhibited in drug and alcohol abuse, antisocial behavior, or other aberrant behavior. Since most schools have programs that deal with these teenage dilemmas, either at school through guidance or after school in a drug and alcohol abuse program, the element of suicide prevention can be built in rather than created in a independent form. The assurance that if a student is contemplating suicide he will have access to help is in itself a sound goal. On the other hand, if several suicides have occurred in the school community, people are prime to begin an established prevention program.

People are the greatest resource. They have ideas, contacts, and fine energy when they are brought together with sound objectives. For instance, teachers see the teenager each day and are often more aware of mood swings than are the parents at home. Students themselves should be enlisted to participate. If the battle belongs to anyone, it belongs to them. They serve as a two-way street to and from the student body, informing peers and carrying peer values in with them. Administrators are a valuable asset for they often deal with the most troubled, the target population of a student body. They also have an experienced value of the parent, the budget, and the staff they represent. The clergy are imperatives. Today more than we imagine, teenagers are leaning toward the Church as a solid emotional standard. The Church has begun a strong trend to modernize its views of teenagers. A few words from the pulpit on Sunday morning can have a tremendous impact on a community that is unsure about its youth, especially about those who try to kill themselves. If there is a school psychologist, especially one who

is specialized in youth counseling, get him in the program. No one will have as many facts than he. His files and readings will convince anyone that the death threat of a teenager is serious. Plus, his contemporary input on referral agencies will be invaluable. Parents care, even if the same parents show for all the volunteer pleas. They will draw others. Ultimately, the most important parent may be the one who has experienced the suicide of his child. This survivor will bring a light from another angle, and he will be dedicated to prevention by means of this experience and hindsight. A policeman can really help since his views are often unlike any of those in the school system. He cares, or he would not be a cop. If he does not care, then he will not come to a meeting, and your problem is solved. The caring officer sees beyond the crime and is alert to adolescent provocation. He can learn and he can teach. The list goes on, and no one should be left out if he represents a a factor that could affect a teenager or if a teenager could affect him.

The idea is a unit of people without only a broad base of input but also with a diverse area of contact to discurse the information of a prevention effort. Call the nurse, the storeowner on Main Street, the council member, the probation officer, the funeral director, the local newspaper reporter. Pour the coffee. From here suicides will be prevented.

In an eighteen month period between 1979, the Gardiner community suffered six adolescent suicides. In response to these tragedies, a Suicide Prevention Committee was formed in conjunction with the existing Drug Advisory Committee. The group was originally chaired by the assistant superintendent and included faculty from the junior and senior high schools, parents, students, clergy, a mortician, and staff of special services. Short range and long range goals were established. They were as follows:

1. Community education and awareness
2. Staff education and awareness
3. Student access to assistance
4. Curriculum development
5. Volunteer intervention training
6. Resource material

Through a concerted effort of the committee members, a curriculum packet was created. It was presented to the staff grades 5-12 in a workshop, and its purpose was explained as supportive to their normal instructional materials, to be used at their discretion in times of assessed need. An emergency telephone number card was prepared and presented throughout the schools and community. Materials were acquired and invented to assist in the curriculum presentation. Committee members presented the ideals of suicide prevention to area organizations and state agencies. These efforts were made within the first year of the committee's existance.

Further efforts by the Suicide Prevention Committee to date have included additions to material supplies and more public presentations. An especially strong relationship with the Drug Advisory Committee has resulted achieved by this combination includes a Crisis Hotline manned by trained volunteers, a peer counseling service which is widely used at the high school, and an improved and updated card and sticker system listing local emergency phone numbers.

Since this work has been implemented in the Gardiner school district there has not been an accomplished adolescent suicide. However, there have been valid attempts and over a dozen threats. The attempts and threats have been evaluated, counseled, and often referred to professional agencies by people who were able to approach the subject with confidence and intelligence. The education and awareness on the part of students, staff and community have been the deciding factors. Furthermore, suicide prevention efforts have served as motivators for adolescents to seek help for themselves or for their friends who display symptoms of serious personal problems.

CHAPTER II

FACTS ABOUT SUICIDE

Incidence

-Nation's tenth leading cause of death.
-Second leading cause of death in adolescents.
-In 1971, 3479 youths (15-24) committed suicide.
-In 1975, 4870 youths committed suicide.
-Suicide rate has increased more than 250%, going from 4.2% in 1954 to 10.6% in 1973 to 12.2% in 1975
-Many deaths which are suicides are not reported as such.
-Many motor vehicle accidents among teenagers are suicides, especially one-car accidents.
-The suicide rate is highest in spring and Christmas holidays
-19% of the present population have made suicide attempts at one time in their lives.
-Incidence of suicides is estimated to be well over 25,000 annually.
-Suicide rates are estimated to be 25 persons per 100,000.

Age and Sex

-Three times as many men as women commit suicide.
-Women make more attempts, usually with less lethal means.
-Incidence increases with age, with more than half of the suicides committed by people over 45.
-The age range is changing with the recent dramatic increase among adolescents.

Marital and Occupational Status

-Suicides higher among divorced persons, followed by widowed, then single.
-Higher among certain professional and occupational groups. (physicians, psychiatrists, lawyers, dentists).
-Higher for unskilled laborers and people with low employment security.

Sociocultural Factors

-Low among religious people, especially Catholics and Muslums
-Suicides decrease during wars, earthquakes, etc.
-Suicides increase during economic depression and unrest.
-Suicide rate is greater in urban than in rural areas.

Methods

-Men use the following methods in this priority order: gunshot, hanging, carbon monoxide, driving, barbiturates, jumping, drugs, cutti

FACTS ABOUT SUICIDE (con't)

Methods

-Women use the following methods in this priority order: barbiturates, hanging, gunshot, carbon monoxide, drugs, jumping cutting.

Intent

-Most people who commit suicide are either ambivalent or do not want to.
-Only 3-5% are intent on dying.
-The more violent the attempt, the more serious the intent.

CHAPTER III: MISCONCEPTIONS ABOUT SUICIDE

1. People who threaten suicide will usually not do it.
   -On the contrary, over 70% who do threaten suicide make an attempt.

2. An unsuccessful attempt means that the person was not serious about it.
   -Some people are naive about how to kill themselves.

3. People don't give clues.
   -They give many clues and warnings. (Saying the world would be a better place without them.)

4. Questioning a depressed person about suicide puts the idea in their head or makes it more acceptable to do it. Also questioning a person about suicide increases the probability of doing it.
   -Not true. The exact opposite occurs. People usually feel a sense of relief or understanding and are glad to talk of it.

5. Suicidal people clearly want to die.
   -No. Most are ambivalent.

6. Only people of a certain class or a certain personality commit suicide.
   -No. All classes and all types of people do it.

7. Membership in a particular religious group is a good predictor that a person will not consider suicide.
   -No. A person's formal religious identification is not an accurate index of true beliefs. Also, suicide does occur in religious people.

8. The motives for suicide are easily established.
   -No. Many times we don't know the true motives.

9. To commit suicide is insane, or one must be mentally ill.
   -No. Most people who attempt suicide are rational and in touch with reality.

10. A person with terminal illness or chronic pain is unlikely to commit suicide.
   - No. Just the opposite is true.

11. Suicide is influenced by the moon, stars, sunspots, etc.
   - No evidence supports this.

12. An improvement in an emotional state of a lessening of depressed moods means lessened risks of suicide.
   - No, not always. When the depression lifts, the person may then have enough energy to actually do it. The factors contributing to the suicidal state need to be modified. Most suicides occur three months after a previous attempt.

13. Once a person is suicidal, he or she is suicidal forever.
   -No. Research has shown that the period which in suicide attempts are critical to occur is brief.

CHAPTER IV: WARNING SIGNS AND CAUSES OF SUICIDE

1. Previous suicide attempts
   - -once engaged in suicide attempts, they become part of a person's repertoire for solving problems.
   - -if under stress, this person is likely to resort to suicide as a solution rather than try another one.
   - -nearly 4 out of 5 suicide victims have attempted it before.

2. Suicide threats
   - -it may be a cry for help so it should be taken seriously
   - -it should not be ignored even if it seems attention getting.
   - -it may be said, "I wish I could die," or "Iwant to kill myself.

3. Depression
   a. Obvious depression
   - -feelings of hopelessness, helplessness, powerlessness, guilt.
   - -no meaning in life, feeling as if one is a burden.
   - -feeling so discouraged, not aware of alternative solutions.
   - -the longer the depression lasts, the greater the risk of suicid

   b. Masked depression
   - -a person is depressed but is able to hide it and not appear depressed.
   - -signs of masked depression are as follows: nightmares, difficulty falling asleep, early morning awakening, loss of appetite, weight loss, lack of energy, difficulty in concentration, tearfullness, fatigue, vague physical complaints.
   - -diliquent behavior such as vandalism, stealing, promiscuity.
   - -excessive use of drugs or alcohol.
   - -school truancy or running away from home.
   - -a sudden decline in grades.

4. Behavioral Change
   - -any sustained deviation from the normal pattern of behavior.
   - -any of the above behaviors.
   - -withdrawing from activities and people and spending time alone
   - -behaving as though one were about to go on a trip.
   - -outgoing person becoming withdrawn; reserved person becoming flamboyant and outgoing.
   - -final arrangements or putting affairs in order such as giving away possessions, talking as if one will not be around, or actually saying goodbye.

5. Experiencing severe stress or crisis
   - -family crisis or arguments, parental arguments and divorce, loss of a loved one, loss of a boyfriend/girlfriend, peer rejection, poor academic performance, failure in some other important area, failure to meet one's own or parental expectations, experiencing chronic pain, serious illness.
   - -a major precipitating stress is the failure to establish, or the loss of, a close relationship.

WARNING SIGNS AND CAUSES OF SUICIDE (con't)

Why do some people who undergo high stress kill themselves or attempt suicide and others do not?

Variables that are associated with high stress increase probability

- -more inflexible in their thinking and restricted in their ability to develop alternative solutions to their problems.
- -the more rigid and inflexible person in personality style.
- -people who are more dependent on others and their environment are more prone to commit suicide under stress, especially if a loss is involved.
- -people who are more impulsive are prone to suicide under stress since they do not have as much self-control.
- -withdrawal of social supports and isolation, no one to turn to or talk to alone, no one who is willing to help during a crisis.
- -persons whose role models have killed themselves are more prone to see suicide as a viable option. (people such as parent, friend, relative, student, star).
- -a developmental history or child rearing behavior on part of the parents that reinforced avoidance behavior. Child was encouraged to avoid solving problems and discouraged problem solving such as parents who solved their child's difficulties rather than allowing him/her to try.
- -Gut Feeling If one has an intuitive sense that a person will harm himself/herself, this is a warning sign.

CHAPTER V: What Can You Do?

A. Upon Receiving a Suicide Threat

This statement must be prefaced with the fact that there is no singular prescribed method of responding to an adolescent suicide threat. The situation will decide the timing and the technique. There are, however, standards to be considered. They are:

1. Take each threat seriously
   -it may be powerful and direct
   -it may be weak and implied

2. Maintain confidentiality
   -of the suicidal student
   -of the contact person

3. Share the responsibility
   -for accountability
   -for assistance

In the event of a situation in which a student threat comes to you from an indirect source such as a friend, the following method has been tried and found to be effective:

1. Evaluate the source
   - what is the motive?
   -what is the relationship?
   -what do others say?

2. Check the records
   -is there an academic change?
   -is there a police file?
   -is there a discipline note?

3. Contact the counselor
   -has there been a teacher comment?
   -has there been a counselor contact?
   -has there been a suicidal gesture?

4. Make a decision
   -contact the student to discuss suicide.
   -contact the student to assess behavior only.
   -contact the parent(s) to discuss suicide.

5. Prepare prevention efforts
   -what referral agencies are appropriate?
   -what in-house personnel are available?
   -who should be informed?

6. Follow up
   -record in case study
   -inform participants of results
   -maintain student contact and observation

Chapter V: What Can You Do? (Con't)

The idea is to confront the threat as soon as possible with as much knowledge as possible. The job is not easy and it is not without emotion. If it is valid, everything will be worthwhile. If it is not valid, then the effort has probably opened communication with a youth who needs to be attended for a number of other counseling reasons.

B. Intervention: A Necessary Component

Let's assume you have identified someone as a high risk candidate for suicide or you have noticed someone who appears depressed, troubled, etc. In general, you have reason to believe that the person is depressed, maybe suicidal: what do you do in your role as a friend, concerned person, teachers, etc.

1. A major issue to be dealt with initially is the following.

   Each of you must decide whether or not you want to get involved and approach a person that you have reason to believe is depressed, or may be suicidal.

2. If you decide to get involved, and the person doesn't approach you, approach the person in order to ascertain if your suspicions are valid. Point out to the person what prompted your concern. Ask open ended questions. Example: "you seem upset, sad, depressed, unhappy or troubled. Would you like to talk about it.? "What seems to be bothering you lately." "I'm concerned about you. Your behaving differently. Is there something bothering you." Communicate to the person that you are concerned about his well being and are willing to listen, talk, understand, and help.

3. If the person denied these difficulties, doesn't want to talk, and is resistant and unresponsive, indicate your concern and availablility in the future. Example: "I know it's difficult to talk about it but I sense that something is wrong and I am concerned about you. Would you like to talk about it." If the person still refuses, one can say something like the following. "If you change your mind, I'd be more than happy to talk." Continue monitoring the persons behavior and periodcially ask him how everything is going for him or her. If your continue to strongly suspect the person is experiencing serious difficulties or is a danger to himself, seek advice from a teacher, parent, or professional (psychologist, psychiatrist, social worker).

4. If the person approaches you and wants to talk or if a person is willing to talk with you after you indicate your availability to talk, do the following:

   Don't moralize or preach. Don't criticize or argue. Don't minimize what he says, e.g. "it's not that bad." Don't avoid the person or cut off the conversation abruptly. If you do this, the person may feel you are revolted by what he is saying and unwilling to help. You may be communicating the message to him that it is not appropriate to talk about suicidal feelings. Don't try to persuade him not to do it right away or

B. Intervention: A Necessary Component (con't)

tell himself or herself to pull himself together or that he should be thankful for what he has. Initially, you should listen to the person and encourage him or her to talk. Communicate to him that you are concerned about him. Try to empathize with him. Communicate to him your very genuine concern. Don't be judgemental. Try to create a non-threatening atmosphere conducive to talking.

5. Encourage the person to talk. Initially, ask open ended questions designed just to enable the person to tell you what he or she is thinking or feeling. If you suspect the person is suicidal or a threat to harm himself, ask him or her directly, e.g. "are you feeling bad enough so that you want to kill yourself or harm yourself." If the person is suicidal by indicitating it to you initially or in responding to the above question, encourage him to talk about it. Ask specific questions. Ask him or her why, if he is told anyone else, how long have you felt this way. How do you plan on doing it, have you tried it, do you think about it all the time or is it just a passing thought, can you control the urge, how strong is it, is there anyone else you can talk to, how do you try to control the urge, what helps you to feel less depressed and have better control over the urge. The above questions help a person to view his suicidal thoughts more objectively and often help bring about some degree of relief. Just talking with another person about suicidal thoughts and feelings and the other person being a willing and accepting listener helps to bring about some degree of relief. Furthermore, the information you get helps you to intuitively determine theseriousness of it. Always try to view and understand the other persons point of view. Try to help him or her realize that you care about him or her. As the person talks, you will make some intuitive, subjective assessment of the severity of the crisis, depression, suicidal thoughts, etc. Each of you will vary, depending upon your training, ability, experience, in how comfortable you will be in dealing with the crisis. A guideline to adhere to is the following:

<u>If you feel you are in over your head</u>, make a referral to an appropriate professional or consult with your parents or a teacher, guidance counselor, etc. To consult with another person, even if the suicidal person says no, is not an act of betrayal. People have strong suicidal feelings usually have temporarily lost their ability to make clear decisions about their lives. You are not betraying him. You are

B. Intervention: A Necessary Component (con't)

helping him. Nine out of ten suicidal people who were prevented from killing themselves were extremely thankful and greatful later on that they were prevented from doing it. If you refer the person to someone else or an appropriate professional, keep in contact with the person or he may feel that you no longer care for him or that you have abandoned him.

6. Once you have subjectively judged that a person is suicidal or experiencing a severe crisis, try to persuade him or her to talk with a teacher or appropriate professional. Try to persuade the person to postpone doing something until he can talk with someone else. Keep in mind that the impulse to kill one's self is usually temporary and brief. Unitl you can persuade or get the person to an appropriate teacher, professional, etc. you want to buy time and get the person to postpone harming himself until the danger period is past or he or she consults a professional. In order to buy time until you can persuade the person or get the person to an appropriate professional you may try some of the following strategies.

   A. Try to provide the person with some intellectual or cognitive understanding to what is happening. Point out to the person that it is a crisis situation and crisis usually pass. Point out to the person that things will improve. Most people who are suicidal find this very difficult to believe but say it to them anyway because it will have an impact on some people. Only do this after you have listened to the person, had time to understand his difficulties, and have communicated your understanding and empathy to him. Once you have done this, your credibility and your ability to influence the person will be much greater.

   B. Ask the person to trust you. Point out that he has tunnel vision and is only seeing the negative and not viewing the situation in the proper perspective as well as not seeing all the options available to him. Ask him to promise you that he will not do anything to harm himself for the time being. Ask him to give your method a chance. Point out that he has nothing to loose by trying this and everything to gain. Point out to him that nine out of ten people who are prevented from killing themselves are extremely thankful later on that they did not kill themselves.

B. Intervention: A Necessary Component (con't)

C. Talk about the pros and cons of suicide. Point out the reasons for living the dying. Ask him to recall the reasons for living that he had during a happier time. He may say something like the following: "even though you may be convinced that suicide is right, lets look at the positive factors in your life and see what you think of them." You may have to suggest positive factors in the persons life as well as the reasons for living. Do this because this helps to increase the persons objectivity and his reasons for dying don't seem as absolute or as compelling as they were before. Don't minimize his reasons for dying. Take them seriously.

D. If you feel a person is seriously suicidal, don't hesitate to involve significant others (parents, teachers, etc.). Ask the person if you can contact his parents. If he or she says yes, feel free to do it. If the person says no and you judge the person to be seriously suicidal or in a serious state of distress, contact parents or teachers. Again, this is not an act of betrayal.

Your overriding concern when you judge a friend or classmate to be suicidal or in a serious state of distress is to talk with him, listen to him, and persuade him to seek help from a qualified professional. If at any time this person is resistant to doing this or you feel very unsure about how to help this person, consult your parents, your teachers, principals, etc.

The preceding information is appropriate for dissemination at the high school and junior high school level. It is applicable to both students, teachers, and concerned individuals.

CHAPTER VI: RESOURCES FOR TEACHERS: AN ACTIVITY PACKET

The enclosed activity packet includes:

1. A quiz on misconceptions about suicide.
2. "To Santa Claus and Little Sisters" - a poem from a 15 year old boy who later committed suicide.
3. An anecdote with background information for the teacher - letter could be handed directly to students or retold
4. An acitivity sheet to help identify common feelings and reactions which could be the basis for a discussion of alternative approaches to problems and negative feelings of rejection, hopelessness, victimization, etc., which often leads to suicide.
5. "The Meaning of Suicide"
6. Discussion Topics
7. Sample Quiz on Suicide

QUIZ ON MISCONCEPTIONS ABOUT SUICIDE

1. Do people who threaten suicide usually carry out the threat?
2. If a person has an unsuccessful attempt does that mean that the person was not serious about it?
3. Do people give clues?
4. Does questioning a depressed person about suicide put the idea in their head or make it more acceptable?
5. Do suicidal people clearly want to die?
6. Is it only people of a certain class or a certain personality or religious group that commit suicide?
7. Is membership in a particular religious group a good predictor that a person will not consider suicide?
8. Are the motives for suicide easily established?
9. Must one be insane or mentally ill to commit suicide?
10. Is suicide influenced by the moon, stars, sunspots, etc.?
11. Is a person with terminal illness or chronic pain unlikely to commit suicide?
12. Does an improvement in an emotional state or a lessening of depressed moods mean a lessened risk of suicide?
13. Once a person is suicidal, is he or she suicidal forever?

This poem was taken from the pamphlet Suicide in Youth and What You Can Do About It, By Russell Lee, M.D., Director of Family Therapy Training at Pacific Medical Center, San Francisco, California and Charlotte P. Ross, Executive Director, Suicide Prevention and Crisis Center, San Mateo County, Burlingame, California.

TO SANTA CLAUS AND
LITTLE SISTERS

Once . . . he wrote a poem.
And called it "Chops."
Because that was the name of
his dog, and that's what is was
all about.
And the teacher gave him
an "A"
And a gold star.
And his mother hung it on the
kitchen door, and read it to
all his aunts. . .
Once . . . he wrote another
poem.
And he called it "Question
Marked Innocence."
Because that was the name of
his grief and that's what it
was all about.
And the professor gave him a "A"
And a strange and steady look.
And his mother never hung it
on the kitchen door, because
he never let her see it. . .
Once, at 3 a.m. . . he tried
another poem. . .
And he called it absolutely
nothing, because that's what it
was all about.
And he gave himself an "A"
And a slash on each damp wrist,
And hung it on the bathroom
door because he couldn't reach
the kitchen.

Written by a 15 year-old boy
two years before he committed suicide

The following is a letter written by a 17 year-old girl to her therapist.

Right now, Dr. Hammer, I wouldn't care if the whole world exploded. I feel very sad and confused. I don't feel as if I am a part of society or anything else for that matter. Why it is that I can't seem to grasp that true self of mine which is floating in the air so close by me? Why are there so many lonely sensitive feelings blocking out the better, happier ones? Who am I? Why did God create such a thing? What was it that happened to me as a child that makes me feel this way? Where are the answers to my ever-haunting questions? I honestly feel like a dead-being roaming the earth. I have no cares for anyone. Do you think it phases me to read about someone dying? Of course not. There are no feelings whatsoever in my soul for anyone.I'm a self-centered person. I guess I could say that I feel sorry for myself. I don't know why I should but I do. Why are there times when I would think of committing suicide? I really don't know but there are. I can't sleep nights, I'm irritable, I don't want people watching me, I like to be alone, I worry a lot. I hate those who ask questions concerning my personal affairs and I hate those who nag. I honestly believe I'll always have these feelings. I'll never rid myself of them. I can't go on living in a world such as this being the person that I am. I put in a terrible night last night. I told God I wanted to die and I really do. I thought of how wonderful it would be to lie there with no more loneliness, heartache, sadness, tears or anything any more. It would be like a long sleep and for once in my life I could be left alone. Death to me is far better than this so-called life. I think it's torture to live here where people do nothing but fight and hate each other. I went to a dance the other night and no one asked me to dance. Don't ask me why. I looked as good as anyone else did. Well, maybe I didn't to those boys. I guess no one likes a sentimental person like myself when everyone else is so fun-loving. I can't understand why I feel like this and why I'm here. I dread the nights. The days aren't too bad, but at night I cry until my face is all swollen. I'm making myself sick. I don't know what to do. I don't see how I've lasted this long. The other night I suddenly became a little girlagain. I wasn't even talking sensible. I found myself crying to my father. Then I could see him sitting beside my bed and he took a hold of my hand and told me he loved me and that I didn't have to be afraid anymore. Then another night I was lying there and suddenly I couldn't feel anything. I couldn't do anything at all. It was like I was mentally retarded, too. Then I could see Mom in the kitchen. She was yelling at me. I wanted to cook something and she told me I didn't know how. I felt ignorant. Everything I touched I dropped. Then I cried real hard. Dr. Hammer, please help me. You're the only person I can turn to. You're the only one that understands me. Nobody knows just how terrible these feelings are. If it last much longer, I don't know what I'll do.

Nina

On numerous occasions Nina had told her therapist of a special tree that she could see from her bench in a small mall-type park, and when she felt hurt or particularly upset she would spend time in the presence of that tree. She had apparently made some kind of identification with it. The next day the letter arrived. (See attached letter)

"The next morning I (Dr. Hammer) received a long-distance telephone call from the mother who was frantic. Nina had not returned from school yet, and now it was several hours past her suppertime. The mother had called the few friends that Nina had, but none had seen her. It was an extremely cold winter's night. The mother could not imagine where the girl could be and hoped that perhaps I might have some idea. I told her to call the police immediately and have them start looking for her. Then I remembered her poem and letter and our past conversation regarding her going to visit the tree at times when she felt most unhappy. I suggested that the mother herself go to the park and search for her there near one of the large trees. I felt that it was very important that the mother be the one to find her. The mother called me back later to tell me that they had found her there and had taken her to the hospital. They found her lying nude in some bushes near the tree. She was suffering from shock and overexposure to the cold but the doctor felt that she would recover. He indicated that greater delay could possibly have been fatal. As I learned afterward, it was her goal to freeze to death, which she had learned was a very painless way to die. "You just fall asleep and it's all over." It also was apparent that in some way she was trying to achieve a kind of mystical union with the tree by dying in its presence."

"She had apparently arranged the "suicide" to use both the therapist and her mother as the rescuer because, as she unconsciously arranged it, it would have been impossible for either one of them alone to have known enought about her at the time to save her. It was also clear that she was committed to die if both people did not come to the rescue. She apparently placed me in the role of the long lost father whom she had never met, fantasizing two loving parents expressing their love for her by coming to her rescue."

"This case typically reflects many of the ingredients that one so often finds in suicide attempts: the feelings of loneliness and isolation, the feelings of numbness as though the feelings of numbness as though one were already dead, the equating of death with peaceful sleep and rest and escape from pain, the uncontrollable obsessive, negative thoughts which make one feel helpless and worthless, the feeling of avoiding all people because they are seen as being too hurting and the recognition that the fear of life is greater than the fear of death. However, most importantly, one sees in suicidal reactions despair rather than just depression. Those extreme feelings of hopelessness suggest to the patient that not only is life painful and miserable now, but they see no possible way it can ever change in the future. Despair involves depression plus pessimism. The prospect of having to endure endless apin and feelings of vulnerability and panic is intolerable to them. At this point, suicide is considered as a serious solution to what they feel are their otherwise insoluble problems. Without the element of hopelessness, depression would very seldom lead to real suicide intent."[1]

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[1]Hammer, Max, Editor. The Theory and Practice of Psychotherapy with Specific Disorders. Charles C. Thomas: Springfield, Illinois, 1972. Chapter 7, pp. 190-218

ACTIVITY SHEET

1. What kinds of situations make you feel sad, hopeless, or rejected? Why?

2. What kinds of situations make you feel good about yourself? Why?

3. Name three kinds of people who make you feel good about yourself. Why?

4. Name three kinds of people who make you feel bad about yourself. Why?

5. Describe an event in your life where you felt hopeless. Why?

6. Describe an event in your life when you felt really good and how you handled yourself. Why?

"The Meaning of Suicide"

Glenn B. is a 25 year old unmarried cousin of yours. You grew up living next door to one another, and although you live in the next town, you don't see much of one another any more. You are friendly when you meet, but your interests are no longer the same.

Approximately two years ago Glenn was diagnosed as having chronic leukemia. His family thought that he had accepted this diagnosis fairly well since he seemed to speak of it quite freely and without much emotion. However, several months ago he went to a faith healer and to a person who "cures" illness through vegetable juices; he proclaimed himself cured and stopped taking his medication. A couple of weeks ago his immature white blood count began to rise (signalling relapse of his illness), and Glenn started becoming very depressed.

Your aunt told your mother that he had stopped eating, slept little, stayed in his apartment, and refused to see his friends or his family; she was very worried about him and intended to contact his doctor with whom he had a good relationship (prior to the faith healing).

A couple of days after hearing this, you run into Glenn coming out of a gun store carrying a large package. He seems pale and withdrawn and barely seems to notice you, until you stop him. When you ask how things are going, he distractedly mutters that things have failed and it's no use going on; he's been a complete fool. He starts to walk off without saying anything else.

What are you going to do?

1. What are some common misconceptions?

   1. People who threaten suicide usually will not do it.

      On the contrary, over 70% who do threaten suicide make a suicide attempt.

   2. An unsuccessful attempt means that the person wasn't serious about it.

      Some people are naive regarding how to kill themselves.

   3. People don't give clues.

      They give many clues and warnings. e.g. saying the world would be better off without them.

   4. Questioning a depressed person about suicide puts the idea in their head or makes it more acceptable to do it. Also questioning a person about suicide increases the probability of doing it.

      Not true. Exact opposite occurs. Person usually feels a sense of relief and understanding and is glad to talk about it.

   5. Suicidal people clearly want to die.

      No. Most are ambivalent.

   6. Only people of a certain class or a certain personality commit suicide.

      No. All classes and all types of people do it.

   7. Membership in a particular religious group is a good predictor that a person will not consider suicide.

      No. A person's formal religious identification is not an accurate index of true beliefs. Also, suicide does occur in religious people.

   8. The motives for suicide are easily established.

      No. Many times we don't know the true motives.

   9. To commit suicide is insane, or one must be mentally ill.

      No. Most are rational and in touch with reality.

   10. A person with terminal illness or chronic pain is unlikely to commit suicide.

       No. Just the opposite.

11. Suicide is influenced by the moon, stars sunspots, etc.

    No evidence supports this.

12. Improvement in emotional state or a lessening of depressed mood means lessened risks of suicide.

13. Once a person is suicidal, he or she is suicidal forever.

    No. Research has shown that critical period within which suicidal behavior will probably occur is brief.

2. Why do most of us fear or draw back from suicide threats or implications?

    1. Fear of precipitating it by talking about it. Fear of putting it in someone's head.

    2. We don't want to get involved or be bothered.

    3. Uncertainty in how to approach and talk to a suicidal person. Don't know what to do.

    4. We hope that the crisis and suicidal thoughts will disappear by themselves.

3. Is talking about suicide with a person who shows symptons harmful?

    No. It can be a tremendous relief to the person. It gives him an opportunity to express his thoughts and feelings. It is the only way to alleviate suicidal thoughts and feelings. The suicidal person may feel that someone cares and understands. This may be enough to prevent a suicide attempt until the immediate crisis passes or professional help is obtained.

4. Does classroom discussion of suicide and depression hold any value?

    Yes. It can help prevent suicide. It can correct misconceptions that teenagers have. Teenager may find that his feelings aren't so unique. Others have similar problems such as loneliness, peer pressure, problems with parents. He can learn how others deal with their problems and develop new problem-solving strategies. It decreases the sense of separateness and isolation. Teachers serve as role models. If teachers talk about it students will talk about it among themselves.

SUGGESTED DISCUSSION TOPICS

1. Should people who threaten suicide be taken seriously?
2. Unsuccessful attempts. Why did the person fail? What will be the result?
3. Are there clues that a person can identify when someone is considering suicide?
4. What effects can questioning a person directly about his consideration of suicide have upon his future actions?
5. Do people who consider suicide really want to die or truly understand what death is?
6. Does a person's economic or social background affect the probability of his attempting suicide?
7. Does religion relate to prevention of people who might want to commit suicide?
8. How clear are the reasons that a person might have had when he attempted suicide?
9. Does a person have to be mentally ill or emotionally disturbed to attempt suicide?
10. How does terminal illness or chronic pain relate to a person's likelihood of attempting suicide?
11. When a person who is depressed becomes emotionally relieved, the chances of suicide lessen, increase, or remain the same?
12. Does being suicidal remain in a person's being forever?
13. Why do most people draw back or fear suicide thoughts or their implications?
14. Does classroom discussion of suicide and depression have any value?
15. What role does the student or parent or teacher play in suicide prevention?

SUICIDE

TRUE - FALSE

1. People who talk about suicide don't commit suicide. _____
2. Suicide usually happens without warning. _____
3. Most suicidal people are undecided about living or dying. _____
4. Once a person is suicidal, he is suicidal forever. _____
5. Improvement following a suicidal crisis means that the suicidal risk is over. _____
6. Suicide is very "democratic" and is represented at all levels of society. _____
7. Suicide is inherited or "runs in families." _____
8. All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person. _____
9. Suicidal people are fully intent on dying. _____
10. Most of those who commit suicide have given definite warnings of their suicidal intentions. _____

CHAPTER VII

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APPENDICES

A. Death, Dying, Suicide Inventory

B. Assessment as Lethality Scale

C. Publications Order Form

D. A Parent's Letter

Maine Lung Association
128 Sewall Street
Augusta, Maine 04330
207 - 622-6394

TEACHING IDEAS

A DEATH, DYING AND SUICIDE INVENTORY FOR HEALTH EDUCATION CLASSES

Marc E. Meyer

Marc E. Meyer is a health education teacher at North Rockland High School, Thiells, New York 10984.

As a health educator, I have had the pleasure of presenting many new subject areas to high school students. In introducing a unit on death, dying and suicide, I asked my classes the following question: How would you feel if we were to discuss death, dying and suicide in class? The following responses are typical of my classes:

Susan, Grade 11. Sometimes the subject scares me, but so do some other things, and it would be worthwhile.

Jean, Grade 10. I think it would be good to talk about it. Everyone must face it.

Cathy, Grade 11. I feel it's a very mysterious subject and would like to learn more about it.

Glenda, Grade 10. I would like to learn how to deal with it.

Mike, Grade 10. I wouldn't mind if we had a discussion about death. I would be interested to know what other people feel about this topic.

Seth, Grade 10. If it happened in my family, I wouldn't feel good. It wouldn't really bother me to talk about it.

Naomi, Grade 10. It is a fact of life which I have to learn to accept.

Tom, Grade 9. I don't mind discussing death. It will happen at any time.

Cindy, Grade 9. I think it would be interesting to discuss it in class.

David, Grade 9. Death must be discussed since it will be a part of everyone's life.

Robert, Grade 9. I might not like to answer some questions about dying.

I was really pleased with the students' reactions. Their sincere and honest approach enabled us to be a little closer that day.

Death education seems to be a relatively new subject area within the health education curriculum. I believe that it should receive more emphasis in order to enable individuals to face the reality of the death of a close friend or relative.

Below is a thought-provoking inventory dealing with death, dying and suicide. The student is asked to agree or disagree with each statement. Space is provided next to each response for expressing the reason for agreement or disagreement with the statement. Using the space is optional since there may be students who cannot deal in depth with the subject matter.

This activity is an excellent motivator, since there are no right or wrong answers. Students are very likely to experience a sense of involvement through this activity. Each educator must also realize that since some students are unable to deal with this subject and should not be pressured into a response. This subject should be handled in a relaxed and natural manner to insure greater success.

A teacher can use any item in the completed inventory as a springboard to further discussion. This can take place individually, in small groups or with the entire class. Whatever method one chooses, it is important to create an atmosphere of relaxation so that the discussion can be an enjoyable experience.

Death, Dying, Suicide Inventory

Instructions: Place a check (✓) in the appropriate column.

	Agree	Disagree	Reason (Optional)
There is life after death.			
Abortion is a form of murder.			
Everyone must die.			
Everyone is afraid of dying.			
The cost of a burial is high.			
Alcohol abuse is a form of suicide.			
We die a little each day.			
I get uptight about talking about death.			
Children should be allowed to attend funerals.			
Condolences are really not necessary.			
Death should be a happy occasion.			
The use of drugs is a form of suicide.			
A dying person should be told.			
There is no such thing as death.			
Death is life.			
It would be great if everyone could live a few hundred years.			
Death means very little to Americans.			
A terminally ill person should be allowed to die.			
It is important to discuss death, dying and suicide in class.			
Driving fast is a form of suicide.			

Purposes of the American Alliance For Health, Physical Education, Recreation and Dance

The American Alliance is an educational organization structured for the purposes of supporting, encouraging, and providing assistance to member groups and those persons throughout the nation as they seek to initiate, develop, and conduct programs in health, leisure, and movement-related activities for the enrichment of human life.

Alliance objectives include:

1. Professional growth and development—to support, encourage, and provide guidance in the development and conduct of programs in health, leisure, and movement-related activities which are based on the needs, interests and inherent capacities of the individual in society.

2. Communication—to facilitate public and professional understanding and appreciation of the importance and value of health, leisure, and movement-related activities as they contribute toward human well-being.

3. Research—to encourage and facilitate research which will enrich the depth and scope of health, leisure, and movement-related activities, and to disseminate the findings to the profession and other interested and concerned publics.

4. Standards and [illegible]—to further the continuous development and implementation of standards within the profession for personnel, programs in health, leisure, and movement-related activities.

5. Public affairs—to coordinate and administer a planned program of professional, public, and governmental relations that will enhance education in areas of health, leisure, and movement-related activities.

6. To conduct such other activities as shall be approved by the Board of Governors of the Alliance Assembly, provided that the Alliance shall not engage in any activity which would be inconsistent with the status of an educational and charitable organization as defined in Section 501(c)(3) of the Internal Revenue Code of 1954 or any successor provision thereto, [illegible] no part of the assets or earnings shall at any time be diverted to or inured to the benefit of any officers other than the public in the furtherance of purposes and activities consistent with such educational and charitable [illegible]

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CRISIS AND COUNSELING CENTER
Assessment of Lethality

Client's Name_____Age___Sex___Worker_____

Previous Attempts and Circumstances:

Current Problem:

Rating Below is of [ ] Attempt in Progress [ ] Current Suicide Plan

Risk Factors

1. Agent
____1 ingestion, cutting, stabbing
____2 drowning, asphyxiation, strangulation
____3 jumping, shooting

2. Impaired consciousness
____1 none in evidence
____2 confusion, sleepiness
____3 comatose, unconscious

3. Lesions/toxicity
____1 mild
____2 moderate
____3 severe

4. Reversibility
____1 good, complete recovery expected
____2 fair, recovery expected with time
____3 poor, no recovery or permanent damage expected

5. Treatment required
____1 first aid, emergency room care
____2 hospital treatment, routine
____3 intensive care required

Scoring
13-15 high risk
11-12 hi moderate
9-10 moderate
7-8 lo moderate
5-6 low risk

Rescue Factors

1. Location
____3 familiar
____2 nonfamiliar, non-remote
____1 remote

2. Person initiating rescue
____3 signif. ant other
____2 designa. d helper, professional
____1 passerby

3. Probability of discovery by rescue
____3 high, almost certain
____2 uncertain discovery
____1 accidental discovery

4. Accessibility to rescue
____3 asks for help
____2 drops hints
____1 does not ask for help

5. Delay until discovery
____3 no delay to one hour
____2 less than 4 hours
____1 over 4 hours

Scoring
5-7 Least rescuable
8-9 lo moderate
10-11 moderate
12-13 hi moderate
14-15 highly rescuable

TOTAL SCORE

Risk : 100=% Lethality
Risk & Resc .
75-100% mos lethal-pull out all stop
50-74% mode tely lethal-serious att
eval te carefully and push
trea ent
50% equi cal lethality, urge trea
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Suicide Prevention in the Classroom: Curriculum Guide (25)		9.00	
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